## SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

### Individual Rehabilitation Supports *AMENDMENT TO THE PLAN*

| Date of Plan to be Amended: | Name of Person: |
|---|---|

Reason for Change:

☐ Met Goal or Objective ☐ No progress/Limited progress

☐ Person Requested ☐ Other:_____

My goal is to improve or retain skills in the following area:

| | | |
|---|---|---|
| ☐ Personal Care | ☐ Cognitive/independent living skills | ☐ Health and Nutrition |
| ☐ Self-esteem | ☐ Personal Responsibility | ☐ Coping Skills |
| ☐ Medication Management | ☐ Social Skills | ☐ Community Living |

My objective for reaching my goal in the area noted above is:

Personal Care:

Cognitive/independent living skills:

Health/Nutrition:

Self-esteem:

Personal Responsibility

Coping Skills:

Medication Management:

Social Skills:

Community Living:

These activities will help me accomplish my objective:

I plan to work on this objective _____ times weekly _____times monthly

I plan to accomplish this objective by (month/year):

| Date Services to Begin: | 6 month Review Due Date: |
|---|---|

Person:

Parent/Guardian (if person is a minor):

Lead Clinical Staff:

**6 month Review**

Progress made toward accomplishing goal/objective? ☐ Yes ☐ No

Issues pertinent to functioning:

Continue Rehabilitation Supports? ☐ Yes ☐ No

LCS Signature: Date: